Uncovering and Enhancing Motivation in a Residential Substance Abuse Treatment Setting

by

Alexandria V. Morris

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Dr. Susan Renes

Dr. Valerie Gifford

Dr. Samantha McMorrow

University of Alaska Fairbanks

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Abstract

This project addresses how to enhance motivation in a residential substance abuse setting in order to encourage completion of treatment. This project discusses contingency management, music therapy, family therapy, and motivational interviewing and how they enhance motivation. Contingency management and music therapy were both found to be helpful in increasing motivation in residential settings. Family therapy was also found to increase motivation, but at smaller levels. Motivational interviewing, which is used by many therapists, also enhances motivation in a consumer and is considered an evidenced based practice. The project provides a motivational curriculum for use in a six-week residential treatment program. The curriculum incorporates all four areas found in the literature that can be used to enhance motivation and to uncover motivation and help to engage consumers in treatment.

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Lack of motivation can be one of the largest obstacles to overcoming substance abuse while in treatment (Klag, Creed, & O'Callaghan, 2010). Korcha and colleagues (2011) found that motivation to change is one of the most important components of substance abuse recovery and is usually studied when consumers enter treatment. DiClemente (1999) stated that being motivated relates to treatment attendance and treatment participation. Since motivation affects behavior change and treatment outcomes, it is an important aspect of after-care treatment and helping clients remain sober following treatment (Groshkova, 2010). Lastly, Hiller, Knight, Leukefeld, and Simpson (2002) found a positive correlation between motivation strength and personal commitment to treatment.

In 2007, the Substance Abuse and Mental Health Services Administration (SAMHSA) (2009a) found that 17.8 million people ages 18 and older were in need of treatment for an alcohol problem. In 2012, 3.7 million people ages 18 and older received treatment for an alcohol or drug problem (SAMHSA, 2012). Of the almost four million, less than one million received treatment in an inpatient rehabilitation center (SAMHSA, 2012). People sought treatment at a variety of other locations including self-help groups, outpatient treatment, outpatient mental health centers, hospitals, doctor's offices, emergency rooms, and prison or jail. The National Institute on Drug Abuse (NIDA) (2008) states that people struggling with drug addiction should receive the same treatment as individuals contending with other chronic illnesses since both relapse rates are extreme. These numbers indicate there is no shortage of people in the United States who need substance abuse treatment. However, locating those potential consumers at a time when their motivation is high enough to engage in treatment is crucial.

Motivation to stay in treatment also affects completion rates. Treatment completion rates vary depending on the type of treatment. According to NIDA (2008), 40%-60% of adults relapse after exiting treatment. Once a consumer makes the decision to attend treatment, helping the individual remain there is critical because the more times a consumer receives 'sober time,' the likelihood of relapse lessens (NIDA, 2008).

This project answers the following research question: "What techniques and interventions will enhance motivation in a residential treatment setting?" After extensive research, a group curriculum was developed that incorporates the information found in this project. The group curriculum integrates songwriting, family therapy, and an incentive based program to enhance motivation.

Stages of Change

Substance abuse theory suggests change happens through different stages and levels of motivation (Hiller et al., 2002). Moving from one stage to the next can be a monumental accomplishment for a consumer. Prochaska and DiClemente's (1983) Transtheoretical Model of the stages of change is important in relationship to motivation. It is important to know what stage of change a consumer may be in, in order to know how motivated they may be for treatment. The stages of change include precontemplation, contemplation, preparation, action, maintenance, and relapse. In the precontemplation stage of change, a consumer does not realize there is a problem and does not intend to change (Laux, Piazza, Salyers, & Roseman, 2012). In the contemplation stage, a consumer is now aware that a problem exists, and begins to think about the problem, but has not made a firm commitment to change. According to Laux and colleagues (2012), the preparation stage occurs when a consumer is ready to make a change within the next month and has recognized the correlation between behavior and consequences. A consumer who has finally

made changes in his or her behavior and environment in order to experience positive change is in the action stage. Lastly, when a consumer works toward avoiding relapse and putting to use all of the tools learned during the action stage, he or she has entered the maintenance stage (Laux et al., 2012).

Relapse is included in the stages of change cycle to show a natural potential to reverting to the previous behavior. In this case, the cycle can start over again, oftentimes with a person moving more quickly through the stages. The viewpoint on relapse in the cycle is not necessarily that it is a stage, but rather, it can occur at any given point during the process. Miller (1999) points out that this does not mean the consumer has given up or abandoned change, but will move to a different stage. Miller (1999) points out that the Stages of Change model is not linear but instead, circular, with consumers continually moving through the different stages.

Finding where a consumer falls on the stages of change cycle or continuum, can help a counselor better meet the consumer's current motivational needs. For example, Giovazolias and Davis (2005) found that consumers in the earlier stages of change prefer interventions that are not as action oriented, whereas those in later stages of change, prefer interventions that are more active. Therefore, consumers who are in the preparation stage will probably benefit from an active intervention; consumers who are still in contemplation will probably benefit from a less active approach. Examples of interventions for people in the earlier stages include raising awareness around the substance abuse problem and self-evaluation, whereas action oriented approaches include contingency management and stimulus control (Giovazolias & Davis, 2005).

Although motivation is important for the consumer to procure, there are certain interventions the counselor can utilize in order to support this motivation. When encouraging a consumer to change, Miller (1999) suggests some of the following strategies: focusing on

strengths, respecting the individuality of the consumer, using empathy, not using authority or power when trying to create a therapeutic bond, and recognizing that oftentimes goals have to be in small increments for progress to occur. When a counselor implements these motivational interviewing strategies to help the consumers move forward and view themselves as individuals aside from their disorder, it helps shift the focus from the clinician onto the consumer and can increase motivation (Miller, 1999).

Motivational Interviewing (MI) and the stages of change are interwoven. Often, when working with the stages of change, a counselor is using motivational interviewing to move the consumer from one stage to the next. However, as with all options, MI does have its limitations. When working with a consumer on a time schedule, MI is difficult because it takes time to resolve the ambivalence (Watson, 2011). Since MI's inception, it has increasingly grown in popularity. Due to this rise in reputation, counselors may begin to have unrealistic expectations of MI. If a person has little or no ambivalence, then MI will not work because the goal of MI is not to change a persons internal values or beliefs (Watson, 2011). Overall, MI should not be viewed as an easy fix, but rather a spirit to adopt while working with consumers.

Assessing Motivation

Assessing how motivated a consumer is to attend treatment in order to help uncover the level of motivation can be done through a variety of measures. Methods noted by Dugosh, Festinger, Lynch and Marlowe (2014) include the University of Rhode Island Change Assessment (URICA), Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES), and the Treatment Readiness Tool (TREAT). The URICA defines each of the stages of change, precontemplation, contemplation, action, and maintenance, and then assesses each stage based on eight items (NCBI, 2005). This measure takes about ten minutes to complete

and five minutes to score. The URICA has been used with both inpatient and outpatient adults and uses 32 items to assess which stage of change a person is in using a continuum format (NCBI, 2005). The SOCRATES looks at readiness to change and assesses recognition, ambivalence, and taking steps (CASAA, 2013). The SOCRATES, along with the URICA, are public assessments that do not require special permission to use. The SOCRATES and URICA differ because the URICA focuses on the general idea of the consumer's problem and stage of change, whereas SOCRATES assesses specifics about drug or substance abuse such as the awareness the consumer has surrounding harm or problems while drinking (CASAA, 2013).

Another, more inclusive scale, includes Circumstances, Motivation, Readiness, and Suitability Scale (CMRS) which measures motivation across four different dimensions (Dugosh et al., 2014). The four dimensions Dugosh et al. (2014) included in the assessment are extrinsic motivation, intrinsic motivation, and preparedness to change behavior, and the suitability of individuals to treatment. The CMRS predicts retention rates for treatment used in both residential and outpatient settings (NCBI, 2005). The CMRS consists of four different scales that measure external pressure that cause consumers to enter treatment, potential external pressures to leave treatment, motivation to change, and readiness for treatment (NCBI, 2005).

Klag and colleagues (2010) looked at measuring motivation through six different types of motivation: amotivation, external motivation, introjected motivation, identification, intrinsic motivation, and internalization. These six types of motivation are supported by the Self-Determination Theory (SDT) which says people are usually either self-motivated to change and are invested in the treatment process, or they feel coerced by external forces. Amotivation describes consumers who refuse to take responsibility for their actions, and believe regardless of what they do, nothing will help them to remain sober (Klag et al., 2010). External motivation is

similar to its name; an example of external motivation is a consumer who attends treatment to avoid legal or custodial consequences. Introjected motivation occurs when a consumer agrees to treatment in order to avoid feelings of guilt and shame. Identification occurs when a consumer recognizes the need to change in order to protect personal health; this motivation is a step above introjected motivation. Intrinsic motivation means that a consumer is attending treatment of his or her own volition and is gleaning the information from treatment and applying the knowledge to a personal recovery. Lastly, internalization describes how a person in the earlier stages of motivation (amotivation, or extrinsically motivated) can become more self-driven by internalizing the external motivator.

The type of assessment used at different facilities will vary from institution to institution. Motivation has a variety of aspects and is not linear; therefore motivation is not easily measured with just one instrument (Miller, 1999). Different instruments are needed for different problems, populations, and stages of change. Consumers can be in different stages of change for different substances as well, therefore possibly being in the action stage for one substance but precontemplation for another. Identifying both the stage of change a consumer is in as well as his or her type of motivation for treatment will help serve the consumer better.

Literature Review

There appears to be a few apparent themes on how to uncover motivation in consumers during residential treatment. The first is prize-based motivation or contingency management plans; they are used as interchangeable terms in the literature. A prized based motivational technique uses different prizes or the possibility of obtaining a prize to encourage consumers to continue participating in their treatment. Through offering these prizes, not only does motivation increase, but retention increases as well (Benishek et al., 2014).

Using music in substance abuse treatment is another effective method of increasing motivation. Different methods of incorporating music into treatment sessions included writing songs, analyzing lyrics, writing parodies of songs, as well as using instruments to create music. All of these different techniques show promise in engaging consumers in treatment and helping to uncover motivation.

Involving the family in substance abuse services and treating the entire family is also important (Miller, 1999). Having the family engage in services, helps to create a safer environment for the consumers to return to once they exit the residential treatment program. Combining family behavioral therapy (FBT) with contingency management is one way of merging two techniques to increase motivation.

Lastly, having counselors who adopt the motivational interviewing spirit often helps consumers uncover their own motivation (Miller, 1999). Although this is dependent on the counselor, not the consumer, the tools used in motivational interviewing can help build the rapport needed for the consumer to feel safe and start to engage in treatment more often (Miller, 1999).

There is a diverse range of literature on substance abuse and how motivation can come from different sources. Andrews, Kramer, Klumper, and Barrington (2012) looked at themes that described the reasons or motivations for clients to enter treatment and found these six themes: (a) influence of family and friends; (b) fear (c) exhaustion (d) disgust with oneself; (e) spirituality; and (f) "rock bottom." However, little research provides information on how to uncover or enhance the motivation consumers may have once they enter treatment.

Techniques in the Literature

There are different techniques to use to enhance motivation during substance abuse treatment. Using music-based interventions, such as group songwriting, have been shown to increase motivation. Contingency systems can also help increase both motivation and retention (Petry, Lewis, & Ostvik-White, 2008). An example of a contingency system could involve giving small prizes every time a consumer attends group or passes a urinalysis, or it could be a larger prize for completing treatment. MI is a tactic used throughout substance abuse treatment because it has shown to enhance engagement and reduces substance use (Davis, Devitt, O'Neill, Kaiser, & Mueser, 2014). MI accomplishes this through both a relational and technical component. The relational component of MI focuses on empathy and the consumer's interpersonal spirit, whereas the technical component focuses on reinforcing the consumer's change talk (Miller & Rose, 2009). Change talk refers to the verbalizations consumers make that reflect the behavior they want to achieve.

Miller (1999) discusses an approach called FRAMES that can inspire motivation in a consumer. FRAMES stands for feedback, responsibility, advice, menu, empathetic, and self-efficacy. FRAMES begins with offering the consumer feedback based on a substance use patterns assessment and compares their scores/behaviors to that of a national average or other treatment groups. Next, the consumer can either take responsibility for their substance use and continue or cease their use (Miller, 1999). The counselor then suggests alternatives but does not tell the consumer what to do because this shows power and authority and the consumer may stop participating in treatment. The M in the FRAMES acronym stands for menu, which refers to the variety of options given to the consumer of different changes he or she can make to alter current use patterns. Empathy given by the counselor to the consumer may also help elicit positive

change by expressing warmth and understanding (Miller, 1999). Lastly, the consumer needs self-efficacy and the counselor helps with this through empowering and encouraging the consumer. According to Miller, these simple motivational interventions can help consumers return for another session, stay involved in treatment, and increase treatment compliance.

Prize-Based Motivation

Using financial incentives or prizes for substance abuse treatment is widely used. Jongsma, Peterson, and Bruce (2014) describe two different reward base interventions: earning rewards for having a negative urine analysis and earning rewards for continuing to attend treatment. The interventions start at the low end of $1 and can increase in monetary value to $100 the longer consumers continue abstinence or continue to attend treatment.

Contingency management is receiving a positive reinforcement for abstaining from substances. Benishek et al. (2014) describes two of the most effective contingency management programs, voucher-based reinforcement therapy (VBRT) and prize based contingency management. This therapy gives out vouchers that say 'good job,' small prize, large prize, or jumbo prize. The majority of the vouchers all say good job (or other verbal praise) but the more the consumers complete the task and receive the voucher, the more likely they are to potentially draw a larger prize (Benishek et al., 2014). Benishek conducted at a meta-analysis of data analyzing how effective the prize-based system was in comparison to regular treatment without a contingency-based system. Through a large literature review, Benishek and colleagues found that using a prize-based contingency management system helped to increase abstinence among consumers when the intervention was being used. However, once the prize-based system ended, the effectiveness decreased and was not present at the 6 month follow up. Benishek et al. noted

that this finding demonstrates the importance of follow up for substance abuse consumers due to the high rate of relapse.

Srebnik and colleagues (2013) found similar results in their study with substance abuse consumers who also had a co-occurring severe mental illness (SMI). The study took place at University of Washington with 29 participants who had used a stimulant in the past 30 days and met the criteria for schizophrenia, schizoaffective disorder, bipolar disorder, or major depression. These participants were between the ages of 18 and 65 years old. The staff participated in the study and included eight supervisors and 72 line staff, who were comprised of case managers and administrative staff (Srebnik et al., 2013). The majority of the staff held Masters degrees and possessed an average of 9 years of experience working with a variety of consumers. Seventy-three percent of the participants identified themselves as mental health clinicians, whereas 13% identified themselves as addictions counselors (Srebnik et al., 2013). The specific demographics of the participants and the consumers were not provided.

The study examined the clinicians and consumers views regarding contingency management. The contingency management program used by Srebnik and colleagues (2013) was drawing prizes from a bowl with the opportunity to draw increasing with each week of abstinence. Consumers found the contingency management helpful because it helped them to remain sober and provided a method for accountability in order to maintain sobriety. In addition to consumers having positive reactions to contingency management, clinicians responded positively as well. Seventy-seven percent of the clinicians interviewed in the study reported that they would utilize contingency management provided the funds were available. Although both consumers and clinicians agreed that contingency management helped to provide motivation for

continued abstinence, funding continues to be a problem for most treatment facilities (Srebnik, 2013).

Even though the attitude of the clinicians in the study completed by Srebnik and colleagues (2013) was positive, the attitudes counselors have towards motivational incentives and contingency management (CM) were found to vary greatly and often depend on the level of experience and exposure to motivational incentives and CM. In a study measuring the attitudes towards motivational incentives and CM, Ducharme, Knudsen, Abraham, and Roman (2010) looked at counselors who had direct exposure to these techniques as well as indirect exposure and whether they received training on the techniques. Recruitment of the participants occurred through mailed out surveys from the National Drug Abuse Treatment Clinical Trials Network throughout the United States (Ducharme et al., 2010). There were about 2,000 participants, of which 64% were female (Ducharme et al., 2010). No additional demographics were collected; the only information collected included gender, when they received their last Masters degree and years of experience in addiction. Almost half of the participants had a Masters degree and averaged about nine years of experience in the field. Measuring the attitudes the counselors had towards motivational incentives and CM occurred through asking their agreement on a seven point scale regarding whether incentives had a positive affect on the client/counselor relationship (Ducharme et al., 2010). The second statement dealt with tangible rewards the client could receive and asked agreement on whether it was appropriate for clients to receive prizes up to $100 for maintaining their abstinence. The first question resulted in more neutral/positive reactions, whereas rewarding with tangible prizes had a higher negative reaction (Ducharme et al., 2010). This article portrays the impact a counselor's attitude has on the types of techniques being used to enhance motivation in a substance abuse setting. Although motivational incentives

and contingency management are evidence-based practices, many counselors who do not have the experience or knowledge of these techniques view them negatively and, therefore, do not utilize them.

A different kind of contingency management that can be utilized involves combining contingency management with religious activities. Petry and colleagues (2008) studied 187 adults who were in substance abuse treatment programs in Connecticut. Requirements for participation included being at least 18 years of age and meeting the DSM-IV criteria for either cocaine abuse or dependence (Petry et al., 2008). The authors did not provide many descriptors of the participants but reported their sample included both genders, and a diverse mix of marital status, income, education level, and race/ethnicity. In addition to a regular contingency management approach, consumers in the treatment facility received rewards for following through with their religious activities. For example, if they stated their religious activity was going to church, attending bible study, or going to a church dinner, they were able to draw from the prize bowl based on completion of the activity. They did not have to choose to go to any religious activities during their stay at treatment (Petry et al., 2008). Findings showed that consumers who attended three or more religious activities during their stay in treatment while also participating in contingency management, stayed in treatment longer, had more weeks of sobriety, and had more negative urinalyses (Petry et al., 2008). The results reported were significant even after controlling for other variables that may have affected the outcome such as the number of activities they completed and their baseline urinalysis results, both of which predict treatment outcomes (Petry et al., 2008). Therefore, combining religion with contingency management may also produce longer periods of abstinence for some consumers.

Overall, the contingency management approach to substance abuse appears to be widely used with good results. Contingency management helps to control abstinence or attendance in the short term, and it provides motivation to consumers when they may have trouble being motivated. However, there are pitfalls to contingency management, such as the cost and the short-term nature of the approach. Funding for contingency management is hard to find in community settings and once the approach is removed, consumers often relapse. Less research has been completed on the long-term effects of contingency management.

Music and Substance Abuse

Using diverse music techniques can also help to motivate substance abuse consumers. For example, using songwriting with substance abuse clients in rehabilitation treatment can help with their recovery (Silverman, 2012). After one group session, Silverman (2012) found that the group who received a single group songwriting session and completed the Circumstances, Motivation, and Readiness Scale (CMRS) had higher mean motivation and readiness for treatment scores. This scale measures motivation and readiness for treatment and the likelihood of remaining in treatment (Silverman, 2012). Jones (2005) also found that using songwriting and lyric analysis with a group of participants in treatment brought out emotional change in the participants. Although motivation was not found to increase, feelings of happiness and enjoyment of treatment increased and feelings of guilt and regret decreased after the songwriting session (Jones, 2005). Using songwriting over a longer period could be helpful in recovery for substance abuse clients.

Moe (2011) studied guided imagery and music (GIM) in a group setting to identify changes within each of the consumers during their treatment for substance abuse for 10 weeks. Their research question asked if GIM could help substance abuse consumers rediscover meaning

in their lives after a period of abusing substances. Moe noted that the consumers used in the study were already motivated for change. The consumers spent an hour and a half per week for 10 weeks with 40 minutes spent talking about present situations, 10 minutes spent listening to music, and the last 40 minutes focused on the consumer's physical, behavioral, cognitive and emotional experiences they felt while listening to the music. According to Moe (2011), the overall themes the consumers reported from the GIM were that they felt more coherent about being able to comprehend, manage, and find meaning in their lives. This comprehension, manageability, and meaning could translate into motivation as well. Having the ability to comprehend, manage, and find meaning could mean that the consumers would be more motivated to stay sober since the outcome of the study was similar to others indicating less consumer relapse and readmission to treatment (Moe, 2011). Buino and Simon (2011) noticed that musical interventions within groups also created substantial amounts of group cohesion and positive interaction among group members.

Motivation can be viewed as dynamic, and is influenced by different contexts, such as the therapeutic context and the relationships between consumer and counselor (Dingle, Gleadhill & Baker, 2008). Being motivated to engage in treatment is important in order to increase retention and have a long-term positive outcome. Dingle and colleagues (2008) studied whether music therapy during a cognitive-behavioral group would be effective in engaging consumers in treatment. There were 52 consumers in the study, 46 of which were attending inpatient treatment for an alcohol or a substance abuse related disorder. Of these participants, there were 24 surveys analyzed for feedback. Since many of the consumers attended multiple sessions, they only kept the first survey from each consumer. The 24 surveys consisted of feedback from 10 men and 14 women whose mean age was 35 years old. Thirteen of the surveys were from participants

seeking treatment for alcohol related problems, 10 were from participants seeking help for their substance abuse problem, and one participant did not report a drug of choice. Ninety-minute sessions were conducted once a week with selected songs that were analyzed for their lyrics, parodied by the consumers, or used for singing and listening purposes. Through this approach, the music therapy tied in with the CBT topic of the week to include problem solving, communication, exploring emotions, anger, anxiety, and many other topics. After seven weeks of music therapy, consumers rated the group and almost all of them said they would attend another music session. Dingle and colleagues stated that doing music therapy helped consumers with being motivated for treatment, engage in the group process, and feel more a part of the group.

Culturally, music is also used for substance abuse healing. Most evidence based treatment practices do not always address American Indian and Alaska Native peoples and their own culturally based treatment methods are hard to fund by Western systems (Dickerson, Robichaud, Teruya, Nagaran, & Hser, 2012). Drum therapy has been a long tradition of American Indian and Alaska Native peoples (AI/AN). Dickerson et al. (2012) looked at the effectiveness of drum therapy as a treatment for substance use disorders among AI and AN peoples. The program Drum-Assisted Recovery Therapy for Native Americans (DARTNA) is currently being developed for AI/AN individuals with substance use disorders (Dickerson et al., 2012). Although DARTNA's focus is on drumming, it also incorporates other principles from the 12-step program, talking circles, and references the Medicine Wheel. During the first session of DARTNA, participants create their own drum to use during treatment in order to boost motivation and engagement. After 12 weeks of drum therapy sessions twice a week for three hours each, participants reported on how they liked the session and made recommendations for improvement. There were themes that emerged from the DARTNA sessions such as drumming

being sacred medicine with healing powers; it helped these consumers develop a positive cultural identity, and was overall viewed as being beneficial (Dickerson et al., 2012). DARTNA was also seen as increasing self-esteem, which may increase motivation to stay in recovery from substances (Dickerson et al., 2012).

Drumming circles that are not necessarily culturally based have also shown to enhance the recovery process (Winkelman, 2003). Other programs aside from DARTNA, include 'Drumming out Drugs,' an activity incorporated in substance abuse treatment programs across the United States. Through Winkelman's (2003) research of different therapists and their drumming techniques, he found that drumming enhances recovery through the stimulation of physiological, psychological, and social aspects of the consumer. Drumming in recovery also enhances the cohesiveness of the group as well as a higher sense of awareness for self. Winkelman stated that drumming circles have an important complementary aspect to addiction treatment, especially for consumers who have repeatedly relapsed.

Although music therapy may help consumers become more engaged in treatment, music can serve as a trigger as well. Harakeh and Bogt (2012) reported different trends associated with substance abuse and different genres of music. For example, people who like heavy metal and hip hop music may be more apt to alcohol and drug use. The authors also pointed towards the long list of famous singers who lost their lives to alcohol or drug addictions and how this may romanticize the addictions process for some. Writing lyrics and composing a song can also be overwhelming for consumers and can increase feelings of anxiety (Buino & Simon, 2011). This intervention could be a trigger and met with a lot of resistance. Therefore, Buino and Simon (2011) recommend song writing occur later in the group process when the group feels more

comfortable with one another. Overall, music therapy seems to help more than hinder as long as it is woven throughout the treatment process and used as a learning tool.

Family Involvement in Therapy

The family members that might be involved in substance abuse treatment can vary and include significant others, grandparents, cousins, or other people supporting the consumer. When conducting family therapy, the family is usually viewed as a system, with goals of improving communication, shifting roles, and helping family members become aware of their own needs (SAMHSA, 2004). Involving the family members in treatment with the whole system comprises a lot of work towards prevention, and stopping the substance abuse from moving on in future generations (SAMHSA, 2004). Through family therapy, the family has a platform to make changes, which therefore can motivate the family to change their current patterns (SAMHSA, 2004). SAMHSA (2004) states the reason they conduct very little research on the family within substance abuse treatment is because families can be expensive to research and money is therefore delegated elsewhere.

Family behavior therapy (FBT) is another way to involve and motivate the family as a unit. FBT involves at least one other person in a consumer's life (usually the significant other) who helps the consumer acquire new skills in order to improve the home environment (NIDA, 2012). FBT is set up as an outpatient treatment program where the focus is substance abuse, but it incorporates co-occurring disorders such as depression or family discord (NREPP, 2014). Fifteen sessions occur over six months and there are five interventions involved in FBT. The first intervention involves establishing a behavioral contract so a safe environment can be established using reinforcements for performance of behaviors that are conducive to recovery (NREPP, 2014). Next, the counselor works with the family to establish skills to avoid previous situations

where substances were involved. Next is the implementation of skills in order to reduce the cravings and urges to use, as well as the impulsive behaviors associated with using substances. The fourth intervention involves communication and building a sober support network. Lastly, consumers learn skills surrounding obtaining job or continuing education (NREPP, 2014).

As mentioned, FBT can also be combined with contingency management where the consumer receives awards when goals are accomplished (NIDA, 2012). The difference from the regular contingency management is that the rewards are provided by the significant other or family member, therefore strengthening the bond. According to NIDA, FBT was found to be more supportive than regular counseling, therefore motivating consumers to participate more than without FBT. Benefits from family substance abuse therapy also include the consumer's likelihood to engage in treatment for a longer period (SAMHSA, 2004).

Miller (1999) stated that involving the family in substance use therapy has led to considerable increases in involvement in treatment as well as retention in treatment. Once a significant other (SO) is asked to join a treatment session, this can lead to explaining to the SO how they can provide an important role in the recovery process through emotional support, identifying potential problems, and participating in sober activities with the consumer (Miller, 1999). However, involving a significant other in the treatment process can also be detrimental. The counselor must make sure that the SO is supportive of a substance-free lifestyle and is not experiencing any personal problems that might interfere with remaining supportive (Miller, 1999).

Motivational Interviewing

Motivational Interviewing (MI) emerged in the 1980s as a different way of looking at resistance to change (Watson, 2011). Instead of seeing resistance as an absolute denial for

change, motivational interviewing recognizes that all behavior has a purpose, regardless of how irrational it may be. MI encompasses change and recognizes that each consumer is on a different scale and may be uncomfortable with changing (Watson, 2011). One of the main components of MI is active listening to both sides of a consumer's argument (Watson, 2011). Through this, the goal of MI is to have the consumer recognize his or her own ambivalence and recognize the need for change. Watson (2011) outlines the positive impact motivational interviewing has had on behavioral change and its demonstrated effectiveness in the substance abuse field.

Most researchers agree that MI is not necessarily a compilation of tools or techniques but is instead a way of working with consumers, or it is a 'spirit' that a counselor adopts (Miller, 1999). MI focuses on the client but the counselor is direct and the goal is to explore the different conflicts in a consumer's life that are causing situations not to change. The principles of MI according to Miller (1999) are learning that ambivalence is normal, solving ambivalence through finding intrinsic motivation, having collaboration between the consumer and the counselor, and having empathy.

Five strategies that are helpful for counselors when first meeting with consumer's and practicing MI include using open ended questions, listening reflectively, summarizing, commenting on the consumer's strengths and abilities, and helping the consumer to be self-motivated (Miller, 1999). The goal of asking open-ended questions is to try to start a conversation with the consumer. When using closed-ended questions, the counselor does not give the consumers a chance to expand on areas that may be pertinent or important to them. Through asking open-ended questions, the counselor ensures they cannot be answered with a single-word but instead have to be expanded upon, therefore learning more about the consumer is facilitated (Miller, 1999). Listening reflectively shows the consumer that not only did the

counselor hear what he or she said, but the counselor understood it as well. Through listening reflectively, the counselor builds the therapeutic bond, which may be the first time the consumer has ever had someone truly understand him or her. Summarizing serves a purpose in MI because it helps the counselor to make sure they are on track with what the consumer is sharing. Affirmations given to the consumer demonstrates support and can show the consumer the progress he or she has made in treatment (Miller, 1999). Lastly, through having the consumer verbalize his or her own concerns and intentions about therapy, rather than having the counselor do it, the counselor helps foster the consumer's self-motivation (Miller, 1999).

Application

Motivation plays an important role in residential treatment and engagement of consumers with absorbing the information provided for them. Having a motivational curriculum in a residential treatment program to enhance participation, and uncover motivation the consumers might already have, would be useful. The literature identified four main categories of interventions to enhance motivation during the treatment process: prize-based systems, using music, family therapy, and motivational interviewing. Through combining these techniques, a new motivational curriculum was developed.

The six-week curriculum is designed for a six-week residential treatment program with the idea that the consumers will meet in this group every week. First, the consumers will take two questionnaires to determine their current stage of change as well as their intrinsic and extrinsic motivation. The consumers would take the CMRS in order to measure their current level of intrinsic and extrinsic motivation. These measures will be taken again at the end of their six-week residential treatment in order to measure progress. The CMRS will take place outside

of the regular six-week curriculum in order to provide ample time to focus on the tasks during the group.

The actual curriculum combines a prized-based system with music therapy, along with counselors who are utilizing motivational interviewing and a family component. The prize-based system will guarantee that at least one consumer received a prize for showing up to the session, and every other consumer would have the chance to win a prize by drawing from a "prize bowl." Similarly to Benishek et al. (2014), who implemented a voucher system, there will be a ratio of opportunities to either win, or draw a piece of paper that says 'you're doing great', or a variety of other positive affirmations. The structure would also employ a statistics based system with the more they participate and attend each session, the higher the likelihood of drawing a prize, and not just a positive affirmation. The prizes will increase in value for each session they attend.

However, one of the largest challenges contingency management programs face is funding (Srebnik, 2013). CM programs can still be used through substituting monetary prizes for privileges. If there are certain privileges within a facility that are restricted, using those privileges as rewards could be a motivator towards attending the group. Examples could include extra cell phone time, extra time on the computer, or an extra family visit once a week.

The music therapy portion of the curriculum consists of six different sessions with six different components. The first session involves the consumers identifying their strengths and areas they want to strengthen within their lives as well as analyzing lyrics of different songs in different genres. Miller (1999) noted that important areas to encourage a consumer to change include focusing on their strengths and respecting their individuality. This first session involves intensive motivational interviewing from the counselor. Through MI, a consumer can start to see themselves as a person aside from their addiction, as well as realize they have control over how

they want their treatment to look (Miller, 1999). The consumer has his or her own resources and motivation for change within him or her, the goal is to draw upon the consumer's own goals and values and not have the counselor decide what is most important (Miller, 1999).

The second half of the first session will be analyzing lyrics. The purpose of this session is for consumers to find music they can listen to in their recovery that will be helpful and uplifting for them and help them focus on their strengths, as well as finding the music that causes triggers while in a safe environment. This first group is less action-oriented since Davis (2005) found that consumers in earlier stages of change prefer more passive approaches. As the curriculum continues, the approaches grow more action-oriented.

The second session involves working together in small groups to compose a parody of a song of their choice. The goal of this session is to introduce songwriting in a fun and non-threatening way. Dingle et al (2008) used writing parodies and allowed consumers to bring in examples of songs they wanted to listen to or parody in order to allow consumers to have some choice in the group process. Giving the consumers choice was shown to help both group engagement and participation (Dingle et al., 2008).

The third session involves the group writing a song as a whole. The goal is to continually introduce them slowly to the idea of songwriting through the parody and then working together as a group. After a single group songwriting session, Silverman (2012) found that consumers had higher motivation and readiness to change. Through the group songwriting process, the goal is for group cohesion to form as well.

The fourth session allows consumers to write their own lyrics, they do not necessarily have to put it into music, or sing it aloud, but the goal is to write down their own struggles and identify strategies they use to overcome struggles by way of authoring a powerful song. Jones

(2005) found that even a single session of songwriting could create emotional change within a consumer. Through writing a song, Jones (2005) found that consumers were able to plan, and focus on specific plans. Taking it a step further and performing the song in front of the group was also found to increase self-esteem and provide positive feedback.

The fifth session involves processing how it felt to write the song, whether it was a positive or negative experience, and whether they plan to refer back to their lyrics in time of need. Writing the song and discussing the song are split up into two different groups because Buino and Simon (2011) identified that writing lyrics and composing a song can be overwhelming for consumers and can increase feelings of anxiety and should therefore be done when the group feels more comfortable with each other.

The sixth and final session incorporates a family member into the music session. Involving the family member in treatment with the whole system involves a lot of work towards prevention, and stopping the substance abuse from moving on in future generations (SAMHSA, 2004). At this time, the consumer and family discuss the song the consumer wrote, as well as write a new song for the family. This intervention might be a "chorus" or a family slogan to live by now that the consumer is recovering from their addiction. Miller (1999) also stated that involving the family in substance use therapy has led to considerable increases in involvement in treatment as well as retention in treatment. During the second part of the group, the family and consumer process how music will play a role in the consumer's recovery, if at all, as well as talking about the transition process from treatment back into the home environment.

Through combining these four techniques, a new motivational curriculum was created. This curriculum attempts to uncover motivation in six sessions. After the sixth session, and before they discharge, they would again take the same measures to see if any progress occurred.

Users of this curriculum hopes to fully engage consumers in their own treatment, so that they may gain and process more information and insight from group therapy and apply it personally in their own recovery.

Conclusion

The literature review identified four main areas to enhance motivation in residential substance abuse treatment. Those four areas include using a prize-based management system, incorporating music into the curriculum, using family during treatment, and having counselors adopt the practice of motivational interviewing. Each of these different areas brought a new and different perspective to uncovering motivation and how to go about doing this in a residential setting. The literature also provided insight into how each of those areas could have a negative impact on the treatment process or could be a trigger, such as certain songs (Harakeh & Bogt, 2012). Overall, the literature helped inform the question of how motivation in residential treatment settings aided in the development of a six-week program designed to better engage the consumer.

The six-week group curriculum integrated different aspects of the literature to create a comprehensive group that is designed to help enhance motivation in a residential treatment setting. Through this group, consumers will analyze songs, compose their own songs, and confer with their own family on creating a family song or slogan. Through this process, incentive based approaches will also be utilized in order to motivate the consumer further during the group process. Throughout the sessions, counselors will also adopt and practice the 'spirit' of MI for a thorough integration of the literature and a well-rounded motivational group.

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Music As Motivation

Using music in substance abuse treatment

The following group curriculum emerged out of a literature review regarding contingency management, music therapy, family therapy, and motivational interviewing. The integration of these four techniques is used throughout the group curriculum in order to enhance motivation in a residential group setting. The six-week program starts with participants taking the Circumstances, Motivation, Readiness, and Suitability Scale (CMRS) and will end with this same evaluation in order to measure progress. Throughout the program, participants will listen to lyrics, parody lyrics, write their own lyrics, and also work with their family to create songs as well.

In addition to working with music, consumers will also be enticed with prizes. For each group the consumer attends, their name will be written down and put into a larger prize bucket that will be drawn at the end for $100. For example, if consumers attend the first session, their name will be put in the bucket once. If they attend the second session their name will be put in the bucket twice, and so on. In addition to this, each time they come to group their name is entered into a smaller prize bucket for a $10 coffee card. Therefore, each time they attend group they have the ability to win a prize and set themselves up for a larger prize at the end of the sessions.

Music as Motivation Curriculum

Week 1

Activity: Identifying strengths and analyzing song lyrics

Intended Audience: Volunteers who are beginning residential treatment

Learning Objective: To identify areas of strength and to identify songs that may be triggers as well as identify songs that may be helpful in recovery.

Materials: Stereo system or other device capable of playing music and access to identified songs.

Procedure: Begin with the group check in, work through the list of questions on the curriculum, and give ample time for each consumer to answer. Next, introduce the idea of analyzing song lyrics from popular songs across the decades that may produce triggers. Also, have the availability of playing other, individual songs, depending on the consumer's music preferences. Note that this may not be probable in a large group, but in a small group the consumers could request songs they think may be a trigger.

- Group Check in: What is your greatest strength? What are areas you want to strengthen?
- What's your favorite song?
- Are there certain songs or genres that trigger you or remind you of using?
- What will you do if a song triggers you?
- What will you do if you were already using music as a coping skill and one of the triggering songs come on?

Introducing the Activity: Now we are going to analyze the lyrics of different songs from different genres. The purpose of this is to help find songs that you may find uplifting and helpful, as well as find which songs trigger you. Although you may be triggered, the idea is to experience the trigger in a safe environment where the availability to use is removed. Therefore, you can work through the trigger and recognize it in the future.

Ideas for recovery songs: Aerosmith: "Amazing;" Lynyrd Skynyrd "That Smell;" Macklemore and Ryan Lewis "Starting Over;" Eminem "Going through Changes;" Taylor Swift "Clean;" Kelly Clarkson "People Like Us;" The Beatles "Let it Be;" Aerosmith "Dream On."

Ideas for potential trigger songs: Rehab "Bartender Song;" Lady Antebellum "Bartender;" Lee Brice "Drinking Class;" LMFAO "Shots, Shots, Shots;" Justin Timberlake "Drink you away;" Ray Charles "Let's go get stoned;" Afroman "I got High;" James Taylor "A Junkie's Lament;" O.T. Genasis "Coco;" The Rolling Stones "Mother's Little Helper."

- Which songs were the hardest to listen to? Which were the easiest?
- Are there any songs that definitely bring back memories of using or triggers? Were there any songs that you could use a coping skill?
- What coping skill will you implement if you hear the song and can't turn it off?
- Homework: Begin thinking of the concept of a "parody," we will discuss this in detail next week.

Song Worksheet

Songs I found helpful:

_____

_____

Songs I realized triggered me:

_____

_____

Specific lyrics or themes that I found cause the trigger:

_____

_____

Potential coping skills for hearing music that causes a trigger:

_____

_____

Week 2

Activity: Writing a recovery parody

Intended Audience: Volunteers who have committed to being a part of the Music as Motivation group.

Learning objective: To start learning how to write a song by taking an already created song and changing the lyrics.

Materials: Stereo system or other device capable of playing music.

Procedure: Begin with the group check in, work through the list of questions on the curriculum, and give ample time for each consumer to answer. Next, introduce the idea of writing a parody of a song. Play a few original songs, then play their parodies. Encourage consumer's to be creative, remind them that they will not be graded, and emphasize this is just an activity. The goal of the activity is to turn a song about substances or alcohol into a song about recovery.

- Group Check in: What is the definition of a parody? Does anyone have a favorite parody song? *Definition of a parody is an imitation of a style of writer or artist that is exaggerated in order to increase comic effect.*
- Listen to two original songs and then play their parodies: Party Rock Anthem by LMFAO and the Parody Staying in Anthem (LMFAO Parody); Rude Parody by Benji and Jenna Cowart.
- Encourage consumer's to pick a song from last week that was either a trigger or was about alcohol/substances. Pair the group off into small groups or into pairs. Ask consumers to write a parody of a song and if they cannot manage an entire song, encourage them to write at least two verses.

- After consumers are done with their songs ask if anyone would be willing to volunteer to sing their song to the group, or chant the song in rhythm. If not, ask them to at least read the lyrics aloud.
- How was this experience?
- If you chose to parody a song that was previously a trigger, what was it like writing new lyrics? What felt helpful? If anything?
- For next week, start thinking about if this group had a song, what would it be about?

Parody Worksheet

Song I chose: _____

Main Chorus lyrics:

_____

_____

Parody of song:

_____

_____

_____

_____

_____

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Week 3

Activity: Writing a "group song."

Intended Audience: Volunteers who have committed to being a part of the Music as Motivation group.

Learning objective: To learn how to write a song as a potential coping skill during recovery.

Materials: Stereo system or other device capable of playing music.

Procedure: Begin with the group check in, work through the list of questions on the curriculum, giving ample time for each consumer to answer. Next, introduce the idea of writing a song, especially one about the consumer's own life. Encourage consumers to be creative, remind them that they will not be graded, and emphasize this is just an activity.

- Group Check in: What is your favorite band/group? What are some of the things that group has in common? What are some things our group has in common?
- Today we are going to write a group song where everyone will contribute to the lyrics. This song can be about your experience in treatment, your relationships with each other, or something completely different you may all have in common (general substance abuse, grief, loss).
- What are some potential themes of the group song? We will try to write the first verse together and then everyone will collaborate and work together to write a group song. Please feel free to use the whiteboard, butcher paper, or any other tools you may find useful towards completing this task. I am also staying in the room to answer any further questions you may have.

- After about 30 minutes, (observe them and gauge where they are in the process) ask them to reconvene. How was that experience? Will you share your song? What made you choose the lyrics you did? What about the theme? How was the collaborative process?
- In recovery, we have to reach out to others. Without a sober support network, isolation can lead to relapse. This exercise was to help learn to work together in recovery while also doing a sober activity. Is this something you would ever do again?

Group Song Worksheet

Theme we chose: _____

Main Chorus lyrics:

_____

_____

Entire song:

_____

_____

_____

_____

_____

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Week 4

Activity: Writing a "life song."

Intended Audience: Volunteers who have committed to being a part of the Music as Motivation group.

Learning objective: To express their life difficulties through a musical outlet.

Materials: Stereo system or other device capable of playing music.

Procedure: Begin with the group check in, work through the list of questions on the curriculum, and give ample time for each consumer to answer. Next, introduce the idea of writing a song, especially one about the consumer's own life. Encourage consumers to be creative, remind them that they will not be graded, and emphasize this is just an activity.

- Group check in: What songs cause the largest emotional reaction in you?
- Did anyone use music as a coping skill over the last week? If so, how did it work?
- What did everyone come up with for a "life song?" Let's put some general concepts of this on the board.

For the majority of today's group, you are going to spend time writing a song about your life. This song could be your "anthem," your tale of trials and turbulence, or your future song of the recovery road you hope to take. This song can take on many different meanings and can be organized many different ways. I am going to play some inspirational uplifting music in the background that you might be able to use as a springboard. Please feel free to ask me any questions you may have. You will not be asked to sing this song or put it to music (although you certainly can). This activity is more about expressing yourself.

Life Song Worksheet

Song Title: _____

Main Chorus lyrics:

_____

_____

Entire song:

_____

_____

_____

_____

_____

_____

_____

_____

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_____

Week 5

Activity: Processing consumer's "life song."

Intended Audience: Volunteers who have committed to being a part of the Music as Motivation group.

Learning objective: To express their life difficulties through a musical outlet and share with their product with their peers.

Materials: Stereo system or other device capable of playing music.

Procedure: Begin with the group check in. Ask if any consumer's need extra time to finish writing their song from the previous week. If not, begin asking questions about the process of writing a song.

- Group check in: How has this group been helpful for you?
- Did anyone use their song as a coping skill over the last week? If so, how did it work?
- What did everyone come up with for a "life song?" Let's put some general concepts of this on the board.
- What kind of song did everyone write? Is anyone willing to share what they wrote? Or at least a part of it?
- What was it like to write a song? Difficult? Easy?
- Would you ever do it again?
- Will you use your lyrics in the future to reflect?

Week 6

Activity: Writing a family song or family slogan

Intended Audience: Volunteers who are nearing the end of their residential treatment program and who attended the first and second music group.

Learning objective: To create a family slogan or song that can be used as motivation during difficult times. Also, this activity will help consumers learn ways to incorporate music into recovery with family.

Materials: Stereo system or other device capable of playing music

Procedure: Begin with the group check in, encourage the consumers to discuss the past two sessions with their family members and describe what they have created so far. Next, encourage the family to work together to create a family song or slogan of their choice that can be used as a motivator in the future. Lastly, wrap up the group by thanking group members for their participation and reminding them that they have to take the CMRS before exiting treatment.

- Group Check in: Has music had an impact on your family? Either positive or negative?
- Spend some time talking with your family member about the song you wrote last week. Allow them to read it if you feel comfortable
- How was the experience of sharing your song with someone else? Family members, what did you think of the songs?

Now, for our final project you are going to write a family song or slogan. It does not have to be as long as the original song, but at least two verses or two slogans. Again, this can be about the struggles the family has gone through, looking forward to the future, or an anthem.

- Who is willing to share their family song/slogan with the class?
- Was it difficult to come up with a song? Would you ever do it again? Would you use it in the future?
- How can music continue or start to play a role in recovery for the family?
- Talk about the transition from recovery back home and how the family members can help support the transition.

Informed Consent

Welcome to your group counseling class: Music as Motivation!

This group is intended to increase your motivation towards residential treatment through the use of music. Group counseling can be a powerful tool towards growth, but it also requires vulnerability and being brave. I will ask each of you to 'put yourselves out there' and be vulnerable with the group. If this is something you are uncomfortable with, please know participation in this group is completely voluntary and you can decline participation.

Group has to be a safe environment. For this purpose, everything that occurs in the group room must be kept confidential. This includes anything another group member says or any conversations you have, or anything you hear. Adopt the mantra of 'what happens in the group room, stays in the group room.'

However, there are a few instances where confidentiality must be broken. If there are any verbalizations of child abuse, suicidal ideation, homicidal ideation, or abuse of a person with a disability, I have to report these. I am a mandated reporter so if any of the above topics are brought up, they have to be reported. Aside from that, everything in the group room is confidential.

Although I hope this process is fun, it may be difficult at times as well. I will be challenging you to do things you may have never done before. Be creative, try something new, and have fun. Part of the goal of this class is learning sober activities to use when you are in recovery.

I have read the above information, understand the information, and I agree to the terms of group participation.

Signature of Group Member:

_____

Printed Name of Group Member:

_____

Date: _____

Signature of Facilitator(s):

_____

CTCR
CENTER FOR THERAPEUTIC COMMUNITY RESEARCH

CIRCUMSTANCES, MOTIVATION, and READINESS SCALES for SUBSTANCE ABUSE TREATMENT

CMR FACTOR SCALES
Intake Version

CLIENT ID NUMBER .....(___/___/___/___/___/___/___/___) (1-8)

CLIENT GENDER ..... (___) (9)
1=Male 2=Female

CLIENT ETHNICITY ..... (___) (10)
1=African American 2=Hispanic 3=White 4=Other

CLIENT AGE ..... (___/___) (11-12)

PRIMARY DRUG ..... (___/___) (13-14)
1=Non-crack cocaine
2=Crack
3=Opiates
4=Marijuana
5=Alcohol
6=Poly Drug
8=Other

TREATMENT MODALITY ..... (___/___) (15-16)
1=Drug Free Outpatient
2=Day Treatment
3=Methadone Maintenance
4=Short Term Residential
5=Long Term Residential
6=No Treatment Entered
7=Detoxification Only
8= Detoxification as Entry into Treatment
9=Hospital Inpatient
10=Referral Center
11=Other

DATE OF ADMINISTRATION .....(___/___/___/___/___/___) (17-22)

FOR CTCR USE ONLY. PLEASE LEAVE BLANK.

INSTRUMENT VERSION..... (___) (23)

PROGRAM NUMBER..... (___/___) (24-25)

How you feel can have a powerful effect on treatment. These feelings include your circumstances, the problems in your life, your feelings about yourself, and your feelings about treatment. Carefully consider each of the questions below and indicate how closely they describe your own thoughts and feelings.

Circle the number that best describes your response.

1	2	3	4	5	9
Strongly Disagree	**Disagree**	**Neither Agree or Disagree**	**Agree**	**Strongly Agree**	**Not Applicable**

CIRCUMSTANCES

1.	I am sure that I would go to jail if I didn't enter treatment.	1----2----3----4----5----9	___ (26)
2.	I am sure that I would have come to treatment without the pressure of my legal involvement.	1----2----3----4----5----9	___ (27)
3.	I am sure that my family will not let me live at home if I did not come to treatment.	1----2----3----4----5----9	___ (28)
4.	I believe that my family/relationship will try to make me leave treatment after a few months.	1----2----3----4----5----9	___ (29)
5.	I am worried that I will have serious money problems if I stay in treatment.	1----2----3----4----5----9	___ (30)
6.	Basically, I feel I have too many outside problems that will prevent me from completing treatment (parents, spouse/relationship, children, loss of job, loss of income, loss of education, family problems, loss of home/place to live, etc.).	1----2----3----4----5----9	___ (31)

MOTIVATION

7.	Basically, I feel that my drug use is a very serious problem in my life.	1----2----3----4----5----9	___ (32)
8.	Often I don't like myself because of my drug use.	1----2----3----4----5----9	___(33)
9.	Lately, I feel if I don't change, my life will keep getting worse.	1----2----3----4----5----9	___ (34)
10.	I really feel bad that my drug use and the way I've been living has hurt a lot of people.	1----2----3----4----5----9	___ (35)
11.	It is more important to me than anything else that I stop using drugs.	1----2----3----4----5----9	___ (36)